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UNPUBLISHED

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

PGDH Liquidating Trust, as successor
in interest to Prince George's Hospital,
Incorporated, t/a Doctors' Hospital of
Prince George County,
Plaintiff-Appellant,

No. 92-2068

v.

Louis W. Sullivan, Secretary of
Health and Human Services,
Defendant-Appellee.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
Walter E. Black, Jr., Chief District Judge.
(CA-90-3316-B)

Argued: March 3, 1993

Decided: May 7, 1993

Before HAMILTON and WILLIAMS, Circuit Judges, and
MACKENZIE, Senior United States District Judge for the
Eastern District of Virginia, sitting by designation.

Affirmed by unpublished per curiam opinion.

COUNSEL

ARGUED: H. Lane Kneedler, HAZEL & THOMAS, Richmond, Virginia, for Appellant. Javier Armando Arrastia, Assistant Regional Counsel, Office of the General Counsel, DEPARTMENT OF HEALTH AND HUMAN SERVICES, Philadelphia, Pennsylvania, for Appellee. **ON BRIEF:** Arvin E. Rosen, William L. Siskind, SISKIND, BURCH, GRADY & ROSEN, Baltimore, Maryland; Leslie H. Wiesenfelder, DOW, LOHNES & ALBERTSON, Washington, D. C. for Appellant. Charlotte Hardnett, Acting Chief Counsel, Region III, Office of the General Counsel, DEPARTMENT OF HEALTH AND HUMAN SERVICES, Philadelphia, Pennsylvania; Richard D. Bennett, United States Attorney, Larry D. Adams, Assistant United States Attorney, Baltimore, Maryland, for Appellee.

Unpublished opinions are not binding precedent in this circuit. See I.O.P. 36.5 and 36.6

OPINION

PER CURIAM:

PGDH Liquidating Trust, the successor in interest to Prince George's Doctors' Hospital, appeals the decision of the district court affirming the judgment of the Provider Reimbursement Review Board (PRRB).[1] The PRRB held

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[1]We shall refer to Prince George's Doctors' Hospital and its successor in interest collectively as "PGDH."

that PGDH was not entitled to any additional Medicare reimbursements. Finding no error, we affirm.

I

This case involves a challenge to the interpretation of one of the many complex provisions in the Medicare Act by the Secretary of Health and Human Services (Secretary). Thus, it is helpful for our discussion to begin with an outline of the relevant statutes before discussing the specific facts of this appeal.

A

The General Medicare Program

Medicare is a two-part health insurance program enacted to reimburse the cost of covered medical services provided to eligible elderly and disabled individuals. Prior to major legislative reforms in 1982 and 1983, Part A of the program paid the "reasonable cost" of inpatient hospital services and related post-hospital medical services provided to qualified individuals. Under this system, hospitals would receive payment from Medicare after incurring and billing Medicare for their costs. Part B paid for supplementary benefits for other medical charges, including physician fees, on a "reasonable charge" basis.

Under the pre-1982 system, a hospital was required to furnish the ancillary services that are customarily billed along with room, board, and nursing care. For example, radiology, pathology, and nuclear medicine fell within the definition of "ancillary services." Such ancillary services consisted of a professional component (*e.g.*, physician's fee for interpreting

an x-ray) and a technical or non-physician component (*e.g.*, the overhead, personnel, and equipment necessary to take an x-ray). When the hospital directly supplied the technical component, Part A applied to determine the amount for which Medicare would pay the hospital for these services.

Before the 1982 and 1983 reforms, hospitals often entered lease arrangements with third parties which allowed those third parties, in return for a lease payment, to provide ancillary services to hospital patients.[2] Under the pre-1982 Medicare system, if the lease required the outside supplier to assume all or most of the cost for supplying the technical component of these ancillary services, Medicare would reimburse the third party for these costs under Part B. Thus, if the outside suppliers operated under such a lease arrangement, Medicare paid them for both the technical and professional components of ancillary services which they provided to hospital patients. Leasing the technical component to outside suppliers became known as "unbundling."

In addition, the pre-1982 Medicare system also reimbursed outside suppliers under Part B for the amounts which the outside suppliers paid to the hospital under the lease arrangement. Because of this reimbursement, the hospitals could inflate the lease charges without much resistance from outside suppliers. Thus, Medicare was the only party harmed by these lease arrangements.

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[2]These third parties were commonly referred to as "outside suppliers."

Partly in response to this exploitation by hospitals, Congress enacted the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) *and the Social Security Amendments of* 1983. These statutes and their implementing regulations limited the scope of Part B to reimburse outside suppliers only for their own professional fees. Thus, the new laws required hospitals to "rebundle" the costs for providing the technical component of ancillary services by allowing only the hospital to seek reimbursement for these costs under Part A.

In addition, because the old formula for reimbursing hospitals under Part A created little incentive for hospitals to contain their costs, Congress also changed the formula for reimbursing hospitals under Part A. Specifically, Congress replaced the "reasonable costs" formula with a prospective payment system. Under this new system, Medicare now makes prospective, periodic payments to hospitals at fixed prices, which are determined by placing the patients' medical conditions into particular diagnostic-related groups (DRG). Thus, in effect, Medicare now pays hospitals a predetermined sum based on the particular diagnosis for any given patient. These predetermined amounts include payments for the technical component of ancillary services because, as mentioned above, the hospitals can no longer allow outside suppliers to bill Medicare for these costs.

Because of these significant changes in the Medicare program, Congress recognized that some hospitals who relied heavily on outside suppliers might need time to adjust their billing practices. Therefore, Congress included a waiver provision in the 1983 Amendments. This waiver, referred to as a "Section 602(k) waiver," delayed the rebundling requirement for up to three years for qualifying hospitals.

To qualify for this waiver, a hospital had to satisfy two requirements. First, the outside suppliers' reasonable charges for the non-physician services had to amount to at least 125 percent of the reasonable costs of the non-physician ancillary services furnished by the hospital.[3] Second, the hospital had to demonstrate that its inpatients received at least three types of ancillary services - such as pathology, radiology and physical therapy services - primarily from outside suppliers.

If the hospital qualified for the waiver, then its outside suppliers could continue billing for the technical component of ancillary services provided. Consequently, Medicare would continue to pay a qualifying hospital's outside suppliers for the technical component under Part B. However, the waiver provision did not affect the newly-enacted, prospective DRG payment system to hospitals under Part A. Thus, under the waiver, Medicare paid the hospital (under Part A) and the outside suppliers (under Part B) for the same technical services. In order to adjust for this double payment under Parts A and B for the same services, Congress added an offset provision to the waiver. This offset provided, in relevant part, that:

> Any such waiver shall provide that such billing may continue to be made under Part B of such title but that the payments to such hospital under Part A of such title shall be reduced by the amount of the billings for such services under Part B of such title.

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[3]The parties refer to this requirement as the "125 percent test."

Pub. L. No. 98-21, 97 Stat. 65 § 602(k). In other words, Medicare reduced a hospital's overall prospective Part A payments by the amount which it paid the hospital's outside suppliers under Part B for the technical component of ancillary services.

B

The Maryland Medicare Program

The Medicare system of reimbursement in Maryland differed in one respect from the general system previously described. Specifically, Maryland obtained a demonstration waiver from the Secretary, allowing it to establish its own method for reimbursing hospitals under Part A. *See*, Terms and Conditions (of Maryland's Demonstration Project), Joint Appendix (J.A.) at 58:

> Medicare . . . principles of reimbursement are to be waived with respect to hospitals participating in the [rate setting] experiment. . . . During their periods of participation, such hospitals shall be paid for covered services furnished to Medicare and Medicaid patients according to payment methodologies developed and promulgated by [Maryland].

Under this demonstration project, Maryland's Health Services Cost Review Commission (HSCRC) established its own rates and prospective payment system for reimbursing hospital expenditures under Part A. However, Maryland's system did not address Part B principles of reimbursement.

A major dispute arose between PGDH and the HSCRC regarding the reach of these HSCRC rates. Specifically,

because Maryland's demonstration project only regulated hospital rates, PGDH believed that the HSCRC rates could not regulate the charges for the technical component of ancillary services provided by outside suppliers. However, in January 1985, the Maryland Court of Appeals rejected PGDH's claim in *Prince George's Doctor's Hospital, Inc. v. Health Services Cost Review Commission*, 486 A.2d 744 (Md.1985), holding that the HSCRC rates applied to the technical component of ancillary services regardless of who supplied the services.

C

Particular Facts of this Appeal

After Congress enacted the Section 602(k) waiver, PGDH applied to the Secretary for the waiver on August 22, 1983. The Secretary originally denied this request because the bills submitted by PGDH's outside suppliers to Medicare failed to "separate . . . charges into professional and technical components." J.A. at 97[4]. Thus, the Secretary could not determine whether PGDH satisfied the 125 percent test.

After several rounds of negotiations, PGDH responded to the Secretary's concerns by submitting two schedules which allocated a percentage of its outside suppliers' total billings attributable to their charges for the technical component of ancillary services. Specifically, Schedule I was based on the estimated percentages of each outside supplier's annualized charges which represented the technical component for

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[4]The parties refer to bills which fail to separate the charges into the professional and technical components as "unitary bills."

Medicare inpatients of PGDH. Schedule II estimated these same charges based on statewide averages developed by PGDH's consultants. Although PGDH qualified for the 125 percent test under either Schedule, upon the Secretary's request to select the most appropriate Schedule, PGDH selected Schedule II. Consequently, on December 30, 1983, the Secretary granted PGDH's request for a waiver.

Although the grant of this waiver would have normally triggered the offset mechanism automatically, such was not the case for PGDH. At the time the Secretary granted PGDH's waiver, PGDH and HSCRC disputed whether the HSCRC rates applied to outside suppliers' charges for the technical component of ancillary services. Consequently, during this dispute PGDH never billed under Part A for these services and had, therefore, received no Part A payments for these services. J.A. at 137-39. Instead, only the outside suppliers received reimbursement under Part B for the technical component of ancillary services.

Because there was no double payment by Medicare for the technical component of ancillary services provided by outside suppliers, on July 3, 1984 and at the request of PGDH, the United States District Court for the District of Maryland enjoined the Secretary from using the amounts paid to the outside suppliers for these services under Part B to offset any other Part A payments to PGDH. The district court fashioned the injunction to expire automatically upon resolution of the dispute between PGDH and HSCRC.

Accordingly, in January 1985, after the decision of the Maryland Court of Appeals in *Prince George's Doctor's Hospital*, the district court's injunction automatically dissolved. Thereafter, PGDH received retroactive payments at the HSCRC rates under Part A for the technical component of

ancillary services provided by outside suppliers since the inception of PGDH's waiver. Because this automatically created a double payment for these services, the Secretary imposed a retroactive offset equal to the amounts already paid to the outside suppliers under Part B for these same services.

Because PGDH's outside suppliers had submitted unitary billings to Medicare for Part B reimbursements, the Secretary had no information indicating the actual amounts which Medicare had already paid to outside suppliers for the technical component of ancillary services. Consequently, to determine these amounts, the Secretary applied the Schedule II percentages to the outside suppliers' unitary billings. Under the offset mechanism, the Secretary then used this figure to offset the total Part A payments to PGDH. Unfortunately, under this procedure the offset amount exceeded PGDH's Part A payments for the same services because the HSCRC rates, which controlled the amount of PGDH's Part A payments, were less than the amount of the technical component of the outside suppliers' bills as determined by the Schedule II percentages.[5]

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[5] To fully illustrate the effects of this procedure, we use the same example relied on by the district court. Suppose PGDH's outside supplier (a radiologist) submitted a unitary bill for $100 to Medicare for reimbursement under Part B, reflecting charges for both the professional and technical component of ancillary services provided. To determine the amount attributable to the charges for the technical component of ancillary services, the Secretary applied the appropriate Schedule II percentage (83.5 percent). Thus, the Secretary determined that $83.50 from the outside supplier's unitary bill constituted charges for the technical component. At the same time, PGDH billed Medicare under Part A for

In an effort to obtain an increase in its Part A reimbursements, PGDH challenged the Secretary's offset calculation before the PRRB. PGDH argued that the Secretary should have used the HSCRC rate at which PGDH was paid instead of the Schedule II percentages when determining the amounts which the outside suppliers billed under Part B for the technical component of ancillary services. The PRRB rejected PGDH's argument, causing PGDH to seek judicial review in the United States District Court for the District of Maryland. The district court affirmed the decision of the PRRB.

PGDH now appeals to this court.

II

PGDH presents three primary arguments why the Secretary's actions should not withstand our scrutiny. Specifically, PGDH argues that: (1) once the Maryland Court of Appeals decided that the HSCRC rates applied to charges for the technical component of ancillary services provided by outside suppliers, the Secretary was required to use the HSCRC rates instead of the Schedule II percentages when determining the amount which the outside suppliers actually

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the same services; however, the HSCRC set the rate at which PGDH could bill Medicare for these services at $60.00. Consequently, the amount which PGDH received under Part A for the technical component of ancillary services provided by outside suppliers ($60.00) was less than PGDH's offset for these same services ($83.50). This discrepancy resulted in a net reduction to PGDH's Part A payments of $23.50. PGDH claims that this methodology inflicted an overall reduction of $1,579,647 to its Part A payments from Medicare.

billed for these services (and therefore, the amount of PGDH's offset); (2) the Secretary's refusal to use the HSCRC rates in determining PGDH's offset violated legislative intent because Congress intended the offset to equal, dollar-for-dollar, the amount of Part A payments to hospitals for the technical component of ancillary services provided by outside suppliers; and (3) the Secretary's refusal to adjust PGDH's offset to comply with the HSCRC rates amounted to arbitrary and capricious behavior in light of the Secretary's treatment of other hospitals. Because of our limited standard of review, we reject all three arguments.

A

Under the Medicare Act, 42 U.S.C. § 1395oo(f), judicial review of the Secretary's statutory interpretations and factual findings is governed by principles established in the Administrative Procedure Act (APA), 5 U.S.C. § 500 *et seq.* Because the Medicare Act is "among the most intricate [Acts] ever drafted, "*Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981), APA principles of review require courts to give considerable deference to the Secretary's statutory interpretation unless that interpretation "is clearly contrary to the plain and sensible meaning of the [statute]." *Hart v. McLucas*, 535 F.2d 516, 520 (9th Cir. 1976). In addition, a court need only determine whether the Secretary's factual findings are supported by "substantial evidence." *Universal Camera Corp. v. Nat'l Labor Relations Bd.*, 340 U.S. 474, 487-88 (1951).

Thus, "the standard of review is narrow and this court will not substitute its judgment for that of the agency." *Lloyd Noland Hosp. & Clinic v. Heckler*, 762 F.2d 1561, 1565 (11th Cir. 1985) (citation omitted). Accordingly, a court's task "is the limited one of ensuring that the Secretary did not 'exceed

his authority' and that [any] regulation is not arbitrary or capricious." *Schweiker*, 453 U.S. at 44 (quoting *Batterson*, 432 U.S. at 426). Moreover, a court "need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the [agency's] construction. . . ." *Chevron, U.S.A., Inc. v. Natural Resources Defense*, 467 U.S. 837, 843 n.11 (1984) (citations omitted). Instead, this court must only "determine whether the [agency's] decision was based on a consideration of the relevant factors and whether there was a clear judgment error." *Lloyd Noland Hosp.*, 762 F.2d at 1565.

Applying these principles to the present case, we are constrained to conclude that the Secretary's statutory interpretation must withstand scrutiny. Specifically, we believe that the Secretary followed the express terms of the offset provision and, therefore, did not ignore relevant factors or make a clear error in judgment.

B

The plain wording of the offset provision required the Secretary to offset the Part A payments to PGDH by the amount which PGDH's outside suppliers billed Medicare under Part B for the technical component of ancillary services. Specifically, the offset provision of Section 602(k) provides that:

> Any such waiver shall provide that such billing may continue to be made under Part B of such title but that the payments to such hospital under Part A of such title shall be reduced by the amount of the billings for such services under Part B of such title.

Pub. L. No. 98-21, 97 Stat. 65 § 602(k). Thus, Section 602(k) mandates clearly and unequivocally that before the Secretary could use the HSCRC rates to determine the amount of PGDH's offset, there had to be evidence that the outside suppliers actually billed at those rates.

In the present case, however, there is substantial evidence in the record to suggest that the outside suppliers never actually billed at the HSCRC rates for the technical component of ancillary services and that the HSCRC never enforced its rate regulations on outside suppliers' bills for these services. Specifically, an employee of the HSCRC testified that he had never seen any monitoring, enforcement, compliance action or control over outside suppliers by the HSCRC. This witness also testified that the HSCRC had no authority over outside suppliers, that no notice was ever given to outside suppliers regarding HSCRC's regulatory rates for the technical component of ancillary services, and that the information obtained from PGDH indicated that the outside suppliers' actual billings for these services exceeded the HSCRC rates.

Because the HSCRC rates did not accurately reflect the outside suppliers' actual billings for the technical component of ancillary services, the Secretary had to rely on other data to determine the appropriate amount by which to offset PGDH's Part A Medicare payments. The Schedule II percentages constituted the only data available to the Secretary to make this determination since PGDH's outside suppliers submitted unitary bills and PGDH presented no other evidence suggesting that its outside suppliers billed at rates different than the Schedule II percentages. Consequently, we think

that the Secretary acted reasonably in using the Schedule II percentages to determine PGDH's offset.[6]

C

We also believe that the Secretary did not act arbitrarily or capriciously by refusing to adjust PGDH's offset even though the Secretary adjusted the offset for other hospitals.[7] The Secretary's actions qualify as arbitrary and capricious if the Secretary "relies on factors that Congress did not intend for it to consider, entirely ignores important aspects of the problem, explains its decision in a manner contrary to the evidence before it, or reaches a decision that is so implausible that it cannot be ascribed to a difference in view." *United*

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[6]Nor is our decision incongruous with Congressional intent. Absent Maryland's demonstration project, the DRG formula would control the amount of Part A payments to a hospital operating under a waiver while the "reasonable charge" formula would control the Part B payments to outside suppliers. Because Congress created the DRG payment system to reduce Medicare payments to hospitals, such payments will usually be less than the amount which Part B's "reasonable charge" formula will pay outside suppliers for the same services. Since the offset provision requires the Secretary to offset a hospital's Part A payments by the Part B payments to outside suppliers for the same services, we believe that Congress recognized the possibility that a hospital's offset would not exactly equal its Part A payments.

[7]The Secretary adjusted the offset for: The Carle Foundation Hospital; St. Mary's Hospital; and Rochester Hospital.

States v. F/V Alice Amanda, No. 91-7555, slip op. at 13 (4th Cir. Feb. 26, 1993) (citations omitted). Accordingly, the Secretary "must examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut.*, 463 U.S. 29, 43 (1983) (quotation omitted). In addition, a court should "uphold a decision of less than ideal clarity if the [Secretary's] path may be reasonably discerned." *Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc.*, 419 U.S. 281, 286 (1974).

In the present case, we think the Secretary provided a satisfactory explanation for the differential treatment between PGDH and the other hospitals. Specifically, the Secretary explained that he reduced the offset for other hospitals because, otherwise, the offsets for those hospitals would have included charges for services provided by outside suppliers for which those hospitals received nothing under their Part A payments. J.A. 199-202. In contrast, PGDH's Part A payments paid for the exact same services for which its outside suppliers received payment under Part B. Only the rate of payment for these services differed for PGDH and its outside suppliers. Consequently, PGDH's offset did not include charges for which PGDH received nothing under Part A. Because of this reasonable distinction between PGDH and the other hospitals, we believe the Secretary did not act arbitrarily or capriciously in refusing to adjust PGDH's offset.

D

In summary, because the express terms of the offset statute require the Secretary to use the outside suppliers' actual billing rates and there is substantial evidence that PGDH's outside suppliers did not actually bill at the HSCRC rates, we believe that the Secretary did not ignore relevant factors or commit a clear error in judgment by refusing to adopt the HSCRC rates when calculating PGDH's offset. *Lloyd Noland Hosp.* 762 F.2d at 1565. In addition, we also believe that the Secretary's use of the Schedule II percentages to determine the outside suppliers' actual billing rates (and therefore PGDH's offset) was justified because the Secretary had no other information suggesting the actual billing rates by PGDH's outside suppliers. Finally, we believe the Secretary did not act arbitrarily or capriciously when it refused to adjust PGDH's offset even though the Secretary had previously adjusted the offsets for other hospitals because the Secretary provided a reasonable explanation for this differential treatment.

III

For the reasons stated herein, we affirm the judgment of the district court.

AFFIRMED

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

PGDH LIQUIDATING TRUST *

v. * CIVIL NO. B-90-3316

LOUIS SULLIVAN, etc. *

* * * o0o * * *

MEMORANDUM OPINION

On November 5, 1990, defendant Louis W. Sullivan, Secretary of Health and Human Services, acting through the Provider Reimbursement Review Board, denied the claim of plaintiff PGDH Liquidating Trust for additional payments under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq., commonly referred to as the Medicare Act. Plaintiff filed this action pursuant to 42 U.S.C. § 1395(oo)(f)(l), which provides for judicial review of final administrative decisions rendered by the Secretary. Summary judgment motions have been filed by both the plaintiff (Paper 8) and defendant (Paper 9).

I

These motions raise issues involving the complex governmental structure for reimbursing Medicare providers. To properly resolve these matters, therefore, it is appropriate to set forth some pertinent background information.

Medicare is a two-part health insurance program enacted to cover medical expenses incurred by eligible elderly and disabled individuals. Prior to major legislative reform in 1982 and 1983, Part A paid the "reasonable cost" of inpatient hospital services and related post-hospital medical services. Part B provided supplementary benefits for other medical charges, including physician fees, on a "reasonable charge" basis.

Under the pre-1982 system, a hospital was required to furnish the ancillary services that are customarily billed along with room, board, and nursing care. For example, radiology, pathology, and nuclear medicine fell within the definition of "ancillary services." Such ancillary services consisted of a professional component (e.g., physician's fee for interpreting an x-ray) and a technical component (e.g., the overhead, personnel, and equipment necessary to take an x-ray). If the hospital directly supplied the non-physician component, the "reasonable cost" standard of Part A was applicable. However, where an outside provider entered a lease agreement with the hospital to assume all or most of the non-physician operating costs, that provider could seek reimbursement under Part B's "reasonable charge" basis.

This latter approach developed its own name -- unbundling. With this lease arrangement, outside providers could charge under Part B for the non-physician services and include in those charges the overhead paid to the hospital. By inflating the overhead payments, the outside provider passed the revenue from Part B to the hospital in such a way that all parties derived a financial benefit -- except the Medicare program and its enrollees.

Faced with mounting concern about such exploitation of the system, Congress acted by adopting the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. 97-248, and the Social Security Amendments of 1983. These statutes and their implementing regulations made Part B available only for the physician's own services to individual patients. Thus, hospitals were required to "rebundle" -- that is, to draw the non-physician component back within the operating structure of the hospital and within Part A.

In the name of cost control, Part A was subject to further revision by these statutes. Most importantly, Congress eliminated the "reasonable cost" methodology for many services, instead choosing to create a prospective payment system. Essentially, under this system, Medicare pays to the hospital a fixed price, which is determined by placing a patient's medical condition into a particular diagnosis-related group (DRG).

With such significant changes in the program, Congress recognized that some hospitals would need time to adapt. Moreover, it feared that immediate rebundling at some

hospitals could threaten the stability of patient care. Therefore, Congress included a Section 602(k) waiver in the Social Security Amendments of 1983. This waiver delayed the requirement of rebundling for up to three years for hospitals that had historically provided a substantial portion of their services through agreements with outside providers.

To qualify for this waiver, a hospital was required to satisfy two factors. First, the outside providers' reasonable charges for non-physician services had to be at least 125 percent of the reasonable cost of the non-physician ancillary services furnished by the hospital. Second, the hospital inpatients had to receive at least three distinct types of ancillary services (such as pathology, radiology, and physical therapy services) primarily from outside providers. 42 C.F.R. § 489.23(c)(2). If the hospital successfully fulfilled these factors, the waiver was granted.

In operation, the waiver allowed the hospital to maintain an unbundled structure and thus continue the prior practice of providing non-physician ancillary services through outside organizations. However, Section 602(k) added an offset provision, which is explained by the Provider Reimbursement Review Board in the following way:

> Where a hospital has been granted a Section 602(k) waiver, it receives a DRG payment under Part A which includes an amount for the technical component of the ancillary service even though the hospital is performing only routine services. However, the [outside] supplier continues to bill the carrier under

> Part B and is paid for the same technical component of the ancillary service, along with any additional payment for the professional components. In order to prevent payment for the same service under Part A and Part B, the Part B amount for the technical component of the ancillary service must be subtracted from the Part A DRG payment made to the hospital.
>
> (Hearing Decision, p. 6).

These Medicare principles and reforms, while applicable nationally, were not fully applicable in Maryland. Under a demonstration waiver, Maryland was free to experiment with different cost-control techniques and to ultimately adopt its own prospective payment system, as administered by the Health Services Cost Review Commission ("HSCRC"). Because rebundling brought non-physician ancillary services within the cost base of the hospital, the HSCRC only concerned itself with setting rates for Part A expenditures. As with the federal plan, Part B physician fees escaped Maryland's prospective pay system.

While Maryland's approach worked well with rebundled programs, a question arose concerning the HRCSC's [sic] jurisdiction over hospitals with a 602(k) waiver. Specifically, the question involved the extent to which the HRCSC [sic] could set rates for non-physician ancillary services supplied by outside organizations. A 1985 decision of the Maryland Court of Appeals finally placed this issue to rest, holding in favor of such jurisdiction. Prince George's

Doctors' Hospital, Inc. v. Health Service Cost Review Commission, 302 Md. 193, 205-06 (1985).

II

Against this complicated background, plaintiff's case must be addressed. Plaintiff is the successor in interest to Prince George's Doctors' Hospital, Inc., a 240-bed general hospital that participated in the Medicare program until May, 1985. On August 22, 1983, the hospital applied for a section 602(k) waiver with the Health Care Financing Administration ("HCFA"), an organization within defendant's purview.

To qualify for the waiver, the hospital submitted two schedules to demonstrate that the outside providers' reasonable charges for non-physician services were at least 125 percent of the reasonable cost of the non-physician ancillary services furnished by the hospital. Both schedules focused on the ratio of the non-physician component to the physician component for ancillary services of outside providers. Schedule I represented the ratio as estimated by the outside providers, and Schedule II represented ratios based on statewide averages. Because both schedules satisfied the 125 percent test, the HCFA requested the hospital to choose which set of figures was more appropriate for its facility. The hospital selected Schedule II.

On December 30, 1983, the federal government approved the waiver on the following condition, which embodied the ratios set forth in Schedule II:

the outside suppliers' percentage of non-physician inpatient charges are consistent with the approved waiver as follows:

Department	Non-Physician (Percentages) Charges
Cardiology	63.4
Laboratory	
Clinical	87.5
Anatomical	10.0
Radiology	83.5
Pulmonary Function	73.8

Significant variances (10 percent or more) of these charges by one or more outside suppliers will be cause for HCFA to revoke the waiver.

(Paragraph 2, Waiver Agreement). In addition, the government imposed a further condition that Maryland's HSCRC rate determination would include "all covered inpatient services provided directly by the hospital and the outside suppliers."[1]

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[1]The Court notes that neither party to this litigation made any reference to this provision in the memoranda submitted and no adequate explanation as to its applicability was made during oral argument. In any event, it is of no assistance to the Court here since the HSCRC never determined upon rates for inpatient services provided by plaintiff's outside suppliers.

As applied, the waiver triggered the offset mechanism. An outside provider was to submit a bill under Part B for the reasonable charges for the professional and technical components. Pursuant to section 2804(D)(3) of Provider Reimbursement Manual and 42 C.F.R. § 489.23(c)(3)(iii), the outside provider was required to submit billings that separately identified any non-physician services. However, in plaintiff's case, the provider filed a unitary bill. To ascertain the charge attributable to the non-physician services, the government's Part B intermediary relied on the proportional breakdown of Schedule II as embodied in the waiver. The resulting figure applied as the offset to the hospital's Part A billing for the same non-physician service. As indicated above, after the Court of Appeals resolved the jurisdictional dispute, the HSCRC's prospective payment system dictated any reimbursement allowed under Part A.

To fully illustrate this procedure, the Court shall rely on an example used by the parties in the memoranda and during oral argument. Assuming an outside radiologist provided all the services needed to produce and interpret an x-ray, contrary to the regulations and the Provider Reimbursement Manual's instruction, the radiologist always submitted a unitary bill for $100. Using the Schedule II percentages, the billing intermediary allocated 83.5 percent, or $83.50, to the technical component. At the same time, the hospital billed at the Part A rate as set by the HSCRC which, for the sake of this example, was $60 for the technical component for radiology. Applying the offset requirement,

the HCFA then directed a deduction of $83.50 from the hospital's Part A payment while allowing the hospital to receive only $60 for the identical service. The result of subtracting $83.50 but only adding $60 was a net reduction to the hospital's Part A payment of $23.50.

Plaintiff opposes this reimbursement calculation and seeks to recover $1,579,647, the total amount of the net reductions. Initially, plaintiff filed an appeal with the Provider Reimbursement Review Board. Although plaintiff posed a challenge on many grounds, the crucial issue involved whether defendant should have applied the HSCRC rates on both the Part A and Part B billings, thus creating a dollar-for-dollar offset. In response, defendant asserted that the parties agreed to rely on Schedule II to calculate the offset. Moreover, defendant recognized that, while the HSCRC may have jurisdiction over the non-physician charges of outside providers, it has never exercised its authority to set rates for Part B payments.

After three days of hearings, the board decided that the use of Schedule II for the offset was correct and conformed with congressional intent. In support of this holding, the board found that plaintiff was locked in to applying Schedule II because only this schedule could satisfy the 125 percent test for qualification. Moreover, in the board's opinion, plaintiff could not substitute the lower HSCRC rates for use in Part B because the HSCRC never enforced its authority against outside providers. The board also expressed extreme doubt that plaintiff could fulfill the 125

percent test with the substituted HSCRC rates. For all these reasons, plaintiff did not prevail in its administrative action. Plaintiff appeals to this Court to reverse the board's decision.

III

Although the parties technically move for summary judgment, a procedure that typically focuses on the question of whether there exists a genuine issue as to any material fact, they actually seek Court review of the board's decision. Such review is contemplated by § 1395(oo)(f) of the Social Security Act, which instructs the courts to resolve cases pursuant to 5 U.S.C. § 706, an applicable provision of the Administrative Procedure Act. For example, with respect to the case at bar, the Court must overturn the board's decision "if it is unsupported by substantial evidence in the record, . . . or arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. . . ." Lloyd Noland Hospital & Clinic v. Heckler, 762 F.2d 1561, 1565 (11th Cir. 1985); see also Memorial, Inc. v. Harris, 655 F.2d 905, 910 (9th Cir. 1980). This standard of review, though searching, is narrow. Lloyd Noland, 762 F.2d at 1565.

IV

Upon review of all the facts, the Court affirms the decision of the Provider Reimbursement Review Board. As the Fourth Circuit has emphasized, a court should pay considerable deference to defendant Secretary's interpretation of the complex provisions of the Social Security Act. Randall

v. Lukhard, 709 F.2d 257, 264 (4th Cir. 1983), modified on rehearing in banc, 729 F.2d 966 (4th Cir. 1984), cert. denied, 469 U.S. 872 (1984). The thorough and carefully-reasoned decision of the board is particularly suited to such deferential treatment.

An examination of plaintiff's arguments confirms the appropriateness of the board's ruling. First, it is apparent that HCFA had no choice but to accept Schedule II in light of the deficiencies of Schedule I, which listed the outside providers' estimates of their non-physician components. Not only did the hospital have no written agreements with several providers to substantiate these estimates, but many providers could not distinguish the non-physician component with any reliability (Transcript, pp. 1115, 1216). More importantly, the unrefuted evidence establishes that the hospital agreed to use Schedule II for calculating the offset. Such proof is evident not only from the hearing testimony of HCFA employee Adam Grodecki (Transcript, p.493), but also from the terms of the waiver itself and the subsequent actions of the hospital. Paragraph 2 of the waiver stressed that the proportion of non-physician charges shall be consistent with the Schedule II percentages. That paragraph also included HCFA's right to revoke the waiver in the event that these charges varied by 10 percent or more. The hospital apparently never objected subsequently to this offset procedure (Hrincevich testimony, Transcript pp. 273-74). All of these factors strongly compel application of Schedule II.

Second, the board was correct in rejecting plaintiff's flawed attempt to apply the HSCRC rates to the non-physician component of outside providers. As the record demonstrates, the HSCRC has never set or enforced such rates against outside providers even though it apparently has the authority to do so. (Transcript, pp. 316-17 & 415). In addition, as the board properly recognized, "if the HSCRC rate had been used from the inception of the waiver process, it is extremely doubtful that the [hospital] would have met the 125 percent test based on the data presented in this case."

Equally flawed is plaintiff's assertion that the board committed reversible error by condoning HCFA's violation of 42 C.F.R. § 489.23(c)(3)(iii). This subsection requires the outside provider to "identify the nonphysician services that were furnished, and identify the charge for each service." Specifically, plaintiff claims that HCFA failed to comply with this provision by directing the Part B billing intermediary to apply Schedule II to the outside providers' unitary charges. Plaintiff contends that HCFA should have instead required the outside providers to separately identify the non-physician component. While plaintiff correctly notes that the physician and non-physician components were not separately identified on the billings, it fails to acknowledge that this duty was owed by the outside provider, not the federal government's billing intermediary. Indeed, in the waiver itself, the hospital was specifically required to make the outside supplier honor this obligation. Nonetheless, irrespective of who owed the duty,

the language of paragraph 2 of the waiver is clear: Schedule II identifies the non-physician component.

Finally, the Court finds no support for plaintiff's alternative argument that the board violated equal protection principles by its more favorable treatment of at least three other hospitals with 602(k) waivers. The record reflects that the circumstances surrounding these other hospitals are easily distinguished from the hospital in this case and that plaintiff's assertion has no merit.

In light of all these findings, the Court affirms the board's decision. The record thoroughly demonstrates that the decision was made on the basis of substantial evidence, was neither arbitrary nor capricious, and evidenced a proper application of the law. The Court therefore grants defendant's motion for summary judgment and denies plaintiff's motion for summary judgment and will enter judgment for defendant and against plaintiff. A formal Order will be entered in conformity with this Memorandum Opinion.

August 4, 1992

/s/ Walter E. Black, Jr.
Walter E. Black, Jr.
Chief Judge

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
91-D4

Provider -	Prince George's Doctors' Hospital Lanham, Maryland	Date of Hearing- January 30 and 31, 1990 & June 15, 1990
	Provider No. 21-0051	
	vs	Cost Reporting Periods Ending
Intermediary -	Blue Cross and Blue Shield Association/ Blue Cross of Maryland	June 30, 1984 & May 31, 1985
		Case No. 88-0163

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ISSUE:

Whether the Intermediary's method used to offset Part A payments under Section 602(k) of the Social Security Amendments of 1983, Pub. L. 98-21, was proper?

SUMMARY OF FACTS:

The Provider is a 240-bed, proprietary, acute care, general hospital which participated in the Medicare program from June 1976 until May 31, 1985. On June 1, 1985, substantially all of the assets of the Provider were sold to a publicly-held corporation and the remaining assets were transferred to a liquidating trust formed by the Provider's stockholders. As successor-in-interest to the Provider, the liquidating trust filed an appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff challenging the method used by the Intermediary to offset Medicare Part A payments under Section 602(k) of the Social Security Amendments of 1983, Pub. L. 98-21, for the cost reporting periods in contention. On December 8, 1987, the Board accepted jurisdiction over the Provider's request for hearing. The amount of Medicare reimbursement in controversy is approximately $1,580,000.

Background:

In accordance with Title XVIII of the Social Security Act, the Medicare program was established to reimburse the cost of covered medical services provided to eligible elderly and disabled beneficiaries. Payment under the program consists of two parts. Part A, the hospital insurance benefit program, pays for inpatient hospital services and related post-hospital services. Part B, the supplementary medical insurance program, pays supplementary benefits for certain medical and

other health services not covered by Part A, including physician's services. In order to become a provider of services under the Medicare program, a hospital must meet conditions of participation which includes the provision of certain ancillary services. Ancillary services include those services furnished by facilities (e.g. radiology, pathology, nuclear medicine, etc.) for which charges are customarily made in addition to routine services (e.g. room, board and nursing care). The provision of such ancillary services consists of two parts; the professional or physician component (e.g. physician's fee for reading an x-ray or interpreting an electrocardiogram), and the technical or non-physician component which comprises all services except the physician's care itself (e.g. overhead, personnel, equipment and other non-physician elements of the service.

From the inception of the Medicare program until October 1, 1983, the Medicare program paid for the technical component of ancillary services basically in two different ways. Where the hospital provided the ancillary services, the Medicare intermediary paid the Provider under Part A for the reasonable costs of those services. However, if the hospital and a hospital-based ancillary physician had a contractual arrangement whereby the ancillary physician assumed all or some of the operating costs of a hospital department and that ancillary physician billed directly rather than through the hospital, the Medicare carrier would reimburse the ancillary physician directly under Part B on a total reasonable charge basis. However, effective October 1, 1983, as a result of the enactment of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248 (TEFRA), and the Social Security Amendments of 1983, Pub. L. 98-21, material changes were made with respect to the way the Medicare program would reimburse the ancillary services provided under such contractual arrangements.

TEFRA was enacted, in part, to address an exception to the usual scenario which occurred where hospital departments were leased to physicians. Where a leasing situation existed, physicians were allowed to charge under Part B for the services furnished in their departments and to include in those charges the overhead paid to the hospital. This permitted leased departments to pass revenues from Part B to the hospital in the form of various lease-type payments, to the financial benefit of both parties, but at the expense of the Medicare program and its beneficiaries. The preamble to the regulations implementing the TEFRA amendments described the problem as follows:

> In the past, we have permitted physicians who have entered into [lease or concession] agreements...to claim Medicare Part B reasonable charge payment as payment in full for all services furnished in the provider department including the technical input and overhead costs of producing those services.
>
> However, this practice has led to increasing problems. Since the beginning of the Medicare program, there have been significant changes in the health care marketplace. Third-party cost-based reimbursement has grown to be the dominant method by which health care services are paid for. The rapid increase of health care costs, relative to cost increased in the rest of the economy, has produced a number of local, state, and federal strategies to contain those costs. In turn, many providers have adopted various means of maximizing their reimbursement from major payors such as Medicare. In this context, we

> believe that our longstanding policy related to lease or concession agreements has afforded an opportunity for providers and other parties to make financial arrangements that advantage them at significant cost to the Medicare program....48 Fed. Reg. 8912 (March 2, 1983).

In response to continuing concern over this issue, Congress acted to remedy the problem by enacting Section 108 of TEFRA which provides in pertinent part:

> The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities--
>
> (A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under Part B; and
>
> (B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis.

Under the regulations implementing this TEFRA provision, 42 CFR 405.550(e), payment on a reasonable charge basis under Part B may only be made for the physician's own services to individual patients. The regulations specifically preclude

payments under Part B for the costs of technicians, equipment and other overhead of the hospital department. These technical costs may only be paid on a reasonable cost basis under Part A to the hospital. In addition, these regulatory provisions were specifically made applicable to services of hospital-based physicians in the State of Maryland by terms of the extension of Maryland's demonstration project with the Department of Health and Human Services. However, neither the TEFRA provision nor the regulations addressed the situation where an ancillary service was provided to an inpatient by an independent contractor or supplier which was not assuming hospital overhead but had its own facility and its own overhead. Accordingly, the Medicare program's outlay in such circumstances was theoretically the same as in the pre-TEFRA leasing situation.

In 1983, Congress enacted the Social Security Amendments of 1983, Pub. L. 98-21, which made major revisions in the method of payment for hospital services by creating a system under which payment is made to hospitals prospectively on the basis of a specific rate for each discharge. Under this system, entitled the Medicare Prospective Payment System (PPS), a payment rate was set according to the diagnosis related group (DRG) into which the patient's ailment falls. In addition to this change, Congress took another step to alter reimbursement for various hospital ancillary services by requiring that reimbursement for those services, which had previously been "unbundled" and operated independently from a hospital, be paid only to the hospital. To that end, Congress added Section 1862(a)(14) to the Social Security Act, 42 USC 1395(y)(a)(14), which was known as the "rebundling" provision. The rebundling provision was described in the Federal Register as follows:

> Section 1862(a)(14) of the Act requires that all nonphysician services furnished to a hospital inpatient be paid only as hospital services. This provision was added to the Act to prohibit the practice followed by some suppliers and other providers of billing under Part B of Medicare for nonphysician services that are furnished to a hospital inpatient. This practice has been referred to as "unbundling" and was prohibited effective October 1, 1983, for all participating hospitals, regardless of a hospital's fiscal period or inclusion or exclusion from the prospective payment system.

49 Fed. Reg. 288 (January 3, 1984)

Although Congress intended that the vast majority of hospitals come under the provisions of the Medicare statute, it recognized that some hospitals have historically provided a substantial portion of their services through agreements with outside suppliers. In those hospitals where the services furnished under such agreements were so extensive that the immediate application of the rebundling provision could have threatened the stability of patient care, Congress provided for a waiver delaying implementation of the rebundling provision for up to three years by enacting Section 602(k) of the Social Security Amendments of 1983 which states:

> The Secretary of Health and Human Services may, for any cost report period beginning prior to October 1, 1986, waive the requirements of Sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under Part B of title XVIII of such Act for services

(other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under Part B of such title but that the payments to such hospital under Part A of such title shall be reduced by the amount of the billings for such services under Part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary shall provide for such methods of payments under Part A as is appropriate, given the organization structure of the institution. (Emphasis added.)

The underscored portion of Section 602(k) is referred to as the offset provision or the reduction requirement. Where a hospital has been granted a Section 602(k) waiver, it receives a DRG payment under Part A which includes an amount for the technical component of the ancillary service even though the hospital is performing only routine services. However, the ancillary supplier continues to bill the carrier under Part B and is paid for the same technical component of the ancillary service, along with an additional payment for the professional components. In order to prevent payment for the same service under Part A and Part B, the Part B amount for the technical component of the ancillary service must be subtracted from the Part A DRG payment made to the hospital.

In implementing the Section 602(k) waiver, the regulations at 42 CFR 489.23(c)(2) established the following criteria in order to qualify for the wavier:

(i) The outside suppliers' reasonable charges for nonphysician services in the hospital's base period (as described in Section 405.474(b)(1)

of this chapter) were at least 125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital exclusive of the costs of operating room, recovery room, labor and delivery room, pharmacy, and medical supplies; and

(ii) The hospital's inpatients received at least three distinct types of ancillary services (such as pathology, radiology, and physical therapy services) primarily from outside suppliers.

On August 22, 1983, the Provider applied for a Section 602(k) waiver with the Philadelphia Regional Office of the Health Care Financing Administration (HCFA-RO). In the course of extended negotiations and discussions regarding the Provider's qualifications, the HCFA-RO requested that the Provider furnish a report from each of its outside suppliers regarding what percentage of their charges were for physician's services and what percentage of their charges were for non-physician services. This information was needed to determine if the Provider met the 125 percent test for the waiver. This breakdown would also be important for purposes of the offset requirement if the waiver were granted. After further communications on this matter, the requested information was furnished to the HCFA-RO by letter dated December 14, 1983, which contained two different schedules (Provider's Exhibit K). Schedule I was based on the estimated percentages of each ancillary physician's annualized charges that represented the non-physician/technical component for Medicare inpatients of the Provider. Using Schedule I, the overall charges to costs ratio was 145 percent. Schedule II used percentages of each ancillary physician's annualized charges that represented the non-physician/technical

component based on statewide averages developed by the Provider's consultants. The Schedule II data produced a charges to costs ratio of 173.4 percent. Since either schedule met the 125 percent test, the HCFA-RO requested that the Provider decide which set of figures was appropriate for its facility. The Provider selected Schedule II which showed a greater non-physician charges to costs percentage. On December 30, 1983, the HCFA-RO notified the Provider that its waiver had been granted with the condition that the outside suppliers' percentages of non-physician inpatient charges must be consistent with the percentages contained in Schedule II (Provider's Exhibit L). Another condition established was that the Medicare carrier would report the outside suppliers' non-physician inpatient reasonable charge payments against payments due the Provider for inpatient services in accordance with the Section 602(k) waiver requirements.

At all times relevant to this case, the State of Maryland was operating under a Medicare and Medicaid hospital reimbursement demonstration waiver under the authority of Section 402 of the Social Security Amendments of 1967. A basis condition of the demonstration waiver is that:

> Medicare and Medicaid principles of reimbursement are to be waived with respect to hospitals participating in the experiment and receiving payment under the experimental methodology. During their periods of participation, such hospitals shall be paid for covered services furnished to Medicare and Medicaid patients according to payment methodologies developed and promulgated by the Health Services Cost Review Commission (HSCRC).

Pursuant to the terms of the demonstration project, the payment rates established by the HSCRC under its rate setting system are also used as the basis for Medicare payments to hospitals. From 1980 until January 16, 1985, the Provider was involved in negotiations and litigation with the HSCRC regarding the proper rate structure for the hospital. A major issue in this litigation was whether the HSCRC had the authority to establish rates for the technical components of the charges by the ancillary physicians for services furnished to the Provider's inpatients and outpatients. In January of 1985, the Maryland Court of Appeals rendered its final decision affirming the HSCRC authority over the technical component of these ancillary services. Up until the Court of Appeals' decision, the Provider had never billed under Part A for the technical component of ancillary services furnished by the outside suppliers. After the rate jurisdiction issue was decided by the Court of Appeals, Part A bills at the rates established by the HSCRC were retroactively prepared by the Provider on a claim-for-claim basis for the period of October 1, 1983, through February 28, 1985, (Section 602(k) waiver period).

Throughout the Section 602(k) waiver period, the ancillary physicians had been billing under Part B for both the physician and technical components of the ancillary services. However, a court injunction had prevented the Intermediary from offsetting the technical component charges paid by the Part B carrier against the payments made to the Provider on the grounds that no comparable Part A payment was being made at that time. Upon resolution of the rate jurisdiction issue, the injunction terminated and the Intermediary reinstituted the offset requirement under the Section 602(k) waiver. During the waiver period, the Part B carrier had processed a total of $3,920,705 of outside supplier claims for ancillary services. Applying the Provider-supplied technical component

percentages which were paid under Part B in accordance with Schedule II to Provider's Exhibit K, the Intermediary withheld $3,119,928 from the Provider to avoid making duplicate Part A payments for the same service.

The Provider objected to the Intermediary's adjustments because they were based on the ancillary charges paid by the Part B carrier and the application of the percentages in Schedule II of Exhibit K to determine the technical component offset required under the Section 602(k) waiver. The Provider contended that the offset amount should have been determined based on the rates for the technical component established by the HSCRC which were billed or billable to the Part A Intermediary by the Provider. Based on the HSCRC rates, the Provider determined the total amount billed or billable for the technical component during the Section 602(k) waiver period was $1,540,281. Accordingly, it is the difference between the Intermediary's offset determination of $3,119,928 and the Provider's offset calculation of $1,540,281 which is the issue before the Board in this case.

Provider's Contentions:

The Provider contends that the Maryland system for regulation of hospital rates controls the outcome of this case. In support of this contention, the Provider refers to the Maryland Court of Appeals' decision in Prince George's Doctors' Hospital, Inc. v. Health Services Cost Review Commission, 302 Md. 193, 486 A 2d 744 (1985), in which the court ruled that the technical component of ancillary services provided to hospital inpatients and outpatients is a hospital service within the HSCRC's jurisdiction (Provider's Exhibit R). The Provider asserts that the Court's definitive ruling on HSCRC's jurisdiction is dispositive of the precise issue in this

case regardless of whether the charges were being billed directly by the ancillary physicians or by the hospital. In rejecting the Provider's contention that the HSCRC had exceeded its statutory powers by attempting to regulate rates for ancillary services furnished and billed to patients by lessees, the Court of Appeals held as follows in relevant part:

As we understand it, what is being done here is to regulate the technical component of those ancillary services, not the physician's fees. On this issue the trial judge said:

> "While it is true that the Court of Appeals in Holy Cross Hospital v. Health Services, 283 Md. 677, at p. 689 [393 A. 2d 181] (Holy Cross I) held that '"total costs of the hospital" means the Hospital's expenditures or outlays of money in connection with the operation of the Hospital' it immediately followed the statement of that holding with the statement "[s]ome expenses of a patient's hospital stay traditionally have been included in the bill submitted to the patient by a hospital. For that reason, these expenses would come within the term "total costs of the hospital" as those words are commonly understood, even if there were to be an attempt on the part of any hospital to enter into an independent contract for those services to be supplied through such hospital to its patients.' There is substantial evidence to support the Commission's finding that the technical component of ancillary services has been 'traditionally...included in the bill submitted to the patient by a hospital.' Thus, 'these expenses...come within the term "total costs of the hospital"' even though

> through its arrangements with the physicians rendering the ancillary services these costs have been physically removed from the Hospital's books.... (Emphasis added.)

Consistent with the Court's decision, the Provider contends that the HCFA-RO could not lawfully designate as the technical component portion of the total charges being billed to Part B by the ancillary physicians any amount greater than the HSCRC rate for that technical component. In further support of the position that the HSCRC had jurisdiction to control what the ancillary physicians could charge Provider patients for the technical component, the Provider refers to the testimony of the former Governor of Maryland whose administration introduced the legislation which created the HSCRC. The former Governor testified the intent of the legislation was that all services that were rendered to a patient in the hospital would be regulated by the HSCRC, and included all those services that were rendered to patients indirectly or outside of the hospital purview itself. As long as they were traditional, normal services rendered by hospitals to patients, they were to be regulated. The former Governor further testified that, to the extent the HSCRC did not in fact regulate the charges which the Provider's ancillary physicians were billing directly to hospital patients, the HSCRC would not be exercising its authority or doing the job it was intended to do (TR III, 21-22). Accordingly, it is the Provider's conclusion that the Intermediary could not legally use the Schedule II percentages to determine the technical component for purposes of the offset because those percentages resulted in higher technical component charges to Part B than the HSCRC rates.

The Provider contends that the Intermediary's position as to when Maryland law applies in this case, and when Federal law applies, is a model of inconsistency. As an example, the Provider refers to the HCFA-RO letter of May 15, 1985, (Provider Exhibit T) in which the HCFA-RO states that it had relied on Maryland law in its decision to grant the Provider its Section 602(k) waiver. That decision was based on the position that the HSCRC always had the authority to set rates which included the technical component of services from outside suppliers and that position was upheld by the Maryland courts. Another example cited is the fact that, although Section 602(k) applied only to inpatients, the HCFA-RO unilaterally extended the waiver to cover the Provider's outpatients based solely on Maryland law. In this instance, the HCFA-RO's stated rationale was that, in Maryland, the HSCRC rates apply to all services and, therefore, outpatients must be included in the offset of the approved hospitals' outside suppliers' billings. Since the HCFA-RO had no written authority to extend the Section 602(k) offset to outpatients, there was no basis for this other than Maryland law. The Provider believes the HCFA-RO's selective use of Maryland law typifies the arbitrariness of its position on the amount of the offset. Either Maryland law applies, in which case the amount of the offset must be based on the HSCRC rates, or the HCFA-RO's extension of the waiver to outpatients was illegal. The Provider asserts that Maryland law controls. Accordingly, the rates for the technical component set by the HSCRC are the most accurate measure of the technical component, are absolutely all that the ancillary physicians could charge, and also are all that the Medicare program could pay for the technical component.

The Provider further contends that the HCFA-RO unilaterally imposed the percentages reported on Schedule II to determine the amount of the ancillary physicians' total charges

deemed to represent the technical component. It asserts that Schedule II, which was based on statewide averages, was developed solely as a check on the reasonableness of Schedule I, which was based on the estimated percentages of each ancillary physician's annualized charges that represented the technical component for Medicare inpatients of the Provider. Both of these schedules were submitted to the HCFA-RO for the purpose of meeting the 125 percent test required for approval of the Section 602(k) waiver. Contrary to the Intermediary's allegations, the Provider contends that there was no discussion at the December 22, 1983 meeting between officials of the HCFA-RO and representatives of the Provider of either schedule being used for purposes of computing the required offset. The Provider notes that both schedules exceeded the requirements of the 125 percent test and, therefore, either could have been selected to meet this criteria. If, as alleged by the Intermediary, the Provider had been told not only to select one of the two schedules, but also that the percentages on the selected schedule would be used for the offset, why would the Provider select Schedule II over Schedule I if there was no benefit to be derived. Thus, either the Provider knowingly picked the schedule that resulted in the larger offset to its Part A payments, which is the unsupported version advanced by the Intermediary, or the Provider's selection of Schedule II was solely in the context of the 125 percent test with no mention of the selection having any effect on the offset. The Provider asserts that the only issue it was concerned with at that time was meeting the 125 percent test. The amount of the offset was never an issue until after the Court of Appeals issued its decision on January 16, 1985.

The Provider submits that, as applied to a Maryland hospital, the HCFA-RO's interpretation of Section 602(k) leads to an absurd result to the extent that "the amount of the billings for

such services under Part B" is construed to mean anything other than billings at the proper legal rate as determined by the HSCRC for the technical component under the Maryland system of rate regulation. The Provider further submits that a conflict is created by the Intermediary's interpretation of the offset provision; namely, the inconsistency resulting from using HSCRC rates to calculate the amount the Provider may bill for the technical component under Part A, and the use of estimated percentages based on statewide averages to calculate the portion of the single total charge of each ancillary provider that the HCFA-RO deems to be the amount of the billings for the technical component under Part B. The Provider contends that this inconsistency is precluded by the decision of the Maryland Court of Appeals and by the demonstration waiver entered into between Maryland and HCFA. In Maryland, Medicare has waived the applicability of "reasonable charges" as a basis for determining reimbursement for the technical component. Moreover, the HSCRC has totally preempted the regulation of the technical component of hospital services provided by ancillary physicians to hospital inpatients and outpatients. Therefore, the effect of the Maryland system of hospital rate regulation on this case is to achieve a perfect balance between the "amount of the billings for such services under Part B" for purposes of the Section 602(k) offset provision and the amount of the payments to the Provider under Part A for precisely the same services. However, this event was achievable only because of the coincidence of two factors: One, Maryland is a state which is functioning under a Medicare approved demonstration waiver; and, two, the Maryland Court of Appeals ruled that the HSCRC had jurisdiction to set rates for the technical component of ancillary services regardless of who billed for those hospital services. The Provider notes that, under the Prospective Payment System, the possibility exists that there would be a difference between the "amount of the billings for

such services under Part B" for purposes of the Section 602(k) offset provision and the amount a hospital would be paid under Part A for those same services. This difference exists because the amount billed under Part B is reasonable charges while the amount paid to a PPS hospital under Part A is a calculation made by the Intermediary of the reasonable costs that would have been incurred had the services been furnished under arrangement. However, the Provider asserts that this difference does not exist in Maryland under the HSCRC system.

The Provider contends that it is the HCFA-RO's inconsistent treatment of billings under Part A and Part B for the same hospital services that produced the issue in this case. After the court's injunction on billing was lifted, the HCFA-RO advised the Provider that its Part A bills would be rejected if they were not at HSCRC rates. However, the billings from the ancillary physicians were treated different because the bills were submitted to the Carrier and not to the Intermediary or to the patients directly. To be consistent, the Provider contends that the HSCRC rates should also have been used to determine the portion of the "total reasonable charges" by the ancillary physicians which represented the technical component, and not the estimated percentages. The Provider notes that it was the HCFA-RO's choice to request estimated percentages for purposes of the 125 percent test and to require those estimates to be used in lieu of the actual rates set by the HSCRC. It is the Provider's position that the inconsistency which produced the issue in this case is the result of the choices made by the HCFA-RO and that these choices were erroneous as a matter of law. The Provider concludes that it was inappropriate for the Medicare program to have gone back after the injunction was lifted and after the HSCRC rate jurisdiction case was decided and change its formulation on the Part A side only and not on the Part B

side. The effect of HSCRC jurisdiction was on what the ancillary physicians could bill, and Section 602(k) talks in terms of billings by the ancillary physicians to Part B. If the HCFA-RO's directive to the ancillary physicians regarding those billings was retroactively rendered incorrect by the Maryland Court of Appeals, that is not a mistake which the Medicare program may pass on to the Provider.

Intermediary Contentions:

The Intermediary contends that it properly applied the offset adjustment mandated under Section 602(k) of the Social Security Amendments of 1983. In establishing the offset requirement, the statute states:

> ...the payments to such hospital under Part A of such title shall be reduced by the amount of billings for such services under Part B of such title....

The Intermediary believes that Congress explicitly provided in unambiguously mandatory language that, if outside suppliers billed Part B for the technical component of their services, the amount of the Part A payments to the hospital had to be reduced by the amounts of the outside suppliers' Part B billings. Despite this explicit statutory reference to Part B billings, it is the Provider's position that the offset should be determined by the rates set by the HSCRC for reimbursement under Part A to the hospital for the technical component of ancillary services. It is the Intermediary's position that the offset must be at Part B billing rates and that the use of the HSCRC Part A rates is a clear violation of the Section 602(k) requirement.

The Intermediary believes that federal law controls this case and was properly applied in this situation. In accordance with 42 CFR 405.501, the Medicare carrier determines the amount of reimbursement under Part B for physician services based on the reasonable charge for such services. This determination is independent of, unrelated to, and based on a different methodology from that used in any determination of reimbursement under Part A to a hospital. The Intermediary points out that this is particularly true in Maryland because of the demonstration project, under which Part A Medicare payments to hospitals are based on rates set by the HSCRC. Since the terms of the demonstration project unequivocally state that the Medicare principles of reimbursement are waived only with respect to payments to hospitals, the rates set by the HSCRC only govern payments to hospitals under Part A. The Intermediary affirms that the rates established by the HSCRC have absolutely nothing to do with setting rates for payment by the Medicare carrier under Part B to a person or entity other than a hospital. Absent any provision in the demonstration project regarding Part B payments to physicians or ancillary service suppliers, it is the Intermediary's position that the manner in which the amount of such payments is determined is exclusively a matter of federal law.

Although it is the Provider's belief that state law should control in establishing the amount of any offset, the Provider has not shown what Maryland law prevented the offset as imposed by the Intermediary. Testifying on behalf of the Provider, the former Governor of Maryland was of the opinion that the HSCRC rate setting authority extended to outside suppliers. However, the Intermediary notes that in order to make this assertion, he had to interpret the term "facility" in the Maryland statute to include outside suppliers (TR III, 22-23, 25). Moreover, both the former Governor and another Provider witness who actually had worked for the

HSCRC admitted that they have never seen any monitoring, enforcement, compliance action or control over outside suppliers by the HSCRC (TR I, 77-78, 86, 89-91, 96; TR III, 26-27). The Intermediary believes the most credible testimony on this subject was presented by its witness who is a current member of HSCRC's compliance staff. This witness testified categorically that the HSCRC had no authority over outside suppliers, that no notice was given to outside suppliers of HSCRC rates for the technical component of their services, that no monitoring or compliance actions were taken against outside suppliers, and that information obtained from the Provider indicated that outside supplier billings did not conform to the level prescribed for hospitals for the technical component and were in fact higher. (TR III, 111, 113-118, 125). In summary, the Intermediary believes the cumulative effect of the testimony of the witnesses proved that Maryland law did not apply to the outside suppliers, was never enforced against the outside suppliers even if it did apply to them, and was not followed by the outside suppliers in any event.

The Intermediary argues that its offset avoids paying Part B rates for Part A services whereas the Provider's methodology does not. The Provider correctly notes that there is a cost-containment feature in rebundling which was part of the statutory scheme of the Section 602(k) waiver in PPS hospitals. However, the cost containments desired and mandated by Congress can only be achieved by the offset of the Part B billings against the Provider's Part A payments where a waiver from the rebundling provisions has been obtained. If the Medicare program is allowed to deduct only the Part A payment made for the technical component (i.e., in this case, the HSCRC rate), then the Medicare program's payment for the technical component will effectively have been at the Part B rate to the outside suppliers. Accordingly, the Intermediary concludes that its offset should not be

followed simply because it meets the letter of the federal law, it should also be followed because it is the only way to meet the cost-containment feature of the federal law.

The Intermediary also believes that its offset fulfills the mandates of the HSCRC and conforms to Maryland law insofar as that law is applicable in this case. As the Provider itself suggests, the relevant consequence of HSCRC's final order and the Court's rejection of the Provider's challenge to that order in Prince George's Doctors' Hospital, Inc. v. Health Services Cost Review Commission, 302 Md. 193, 486 A. 2d 744 (1985), is that the Maryland Court upheld the HSCRC's establishment of a form of rebundling in Maryland. Given that the rebundling achieved by the HSCRC final order is also mandated by the Social Security Amendments of 1983 and that the principle of rebundling was expressly added to the terms and conditions of the Maryland demonstration project, the situation in Maryland is precisely analogous to the situation in states where the Medicare PPS is used. If a hospital receives a waiver from rebundling, an offset is necessary to achieve the harmonious federal and Maryland statutory objectives of avoiding duplicate payments for the same services under Part A and Part B. Accordingly, both Maryland and the Medicare program were interested in rebundling, in reducing costs, and in making sure that the technical component was paid at the HSCRC rates and not at the outside supplier charges. Accordingly, the Intermediary asserts that its offset fulfilled both federal and Maryland law. In response to the Provider's intimation that the Medicare program should have reduced the Part B payments to the outside suppliers to conform to the HSCRC rates, the Intermediary argues that the Provider cannot expect the federal Medicare program to enforce a Maryland law which did not even apply. Even if Maryland law did apply to outside suppliers, those suppliers were in fact billing and being paid at

greater than HSCRC rates for the technical component. Therefore, the Medicare program was required to offset at greater than HSCRC rates, even if the outside suppliers were violating Maryland law in so charging. Under the federal statute, the offset was required at actual billing rates, not legal or pretended billing rates.

The Intermediary contends that the technical component percentages which the Provider embraced when the issue was entitlement to the Section 602(k) waiver cannot be later rejected by the Provider when the issue is the amount of the offset under the wavier. The criteria for a waiver and the mandated offset under the waiver both depended upon knowing how much of a Part B charge related to the technical component as opposed to the professional component. Rather than separate the two portions each time a bill was submitted, the Provider chose, with the HCFA-RO's concurrence, to submit a schedule of percentages to break out the Part B charges into the two components by the type of service rendered. The Intermediary used Schedule II from a December 14, 1983, letter submitted by the Provider for these purposes (Provider's Exhibit K). The Intermediary argues that the Provider knowingly and willingly selected the percentages reflected on Schedule II at a meeting with the HCFA-RO, and that the Provider fully recognized that these percentages would be used for purposes of meeting the 125 percent waiver criteria and for the offset computation under the waiver. Moreover, various letters submitted by the Provider during the waiver process (Provider Exhibit I, Intermediary Exhibits 25 and 32) indicated that the Provider understood that the percentages it supplied would also be used for purpose of the offset provision. The Intermediary contends that it would have been completely illogical and unreasonable to use one set of percentages for the 125 percent test and another amount for the offset.

The Intermediary notes that the only other alternative percentages discussed at the December 22, 1983, meeting were those presented on Schedule I of the Provider's letter dated December 14, 1983. At the hearing, the Provider's witness, who served as Chairman of the Board, President and Chief Executive Officer of the Provider referred to the data on Schedule I as a collection of hallway estimates furnished by the ancillary physicians. He also admitted that the Provider picked Schedule II at the HCFA-RO meeting but also indicated that Schedule II was composed of statewide averages unrelated to the Provider. (TR I, 99-100). In response, an Intermediary's witness (Medicare Operations Specialist at the HCFA-RO) testified that the Provider had picked Schedule II as being accurate for its facility (TR II, 68-69). He further testified that Schedule I did not meet basic documentation requirements under the Medicare program, and that under such circumstances the use of other hospital information like the statewide averages in Schedule II would have been appropriate even if the Provider had not stated that Schedule II was accurate for its facility (TR II, 99-101). Based on the testimony of another Intermediary witness (Chief of the Financial Management Branch, HCFA-RO), there would have been an additional problem if the offset was made at the HSCRC rates. Because the amount of the technical component must be used both for purposes of the offset and for purposes of the waiver in the first place, use of the Commission rates would mean that the Provider had been improperly granted the wavier (TR I, 159-160, 193). Having been granted the waiver using a technical component rate other than the HSCRC rate, the Provider may not now revert to the HSCRC rate for purpose of the offset.

The Intermediary concludes that the offset of Part A payments by the Part B billings conforms to the letter and spirit of both federal and state law. Should the Board

disagree and require an offset at the HSCRC rates, then the Intermediary requests that the case be remanded for further audit work to determine what these rates were and to account for the overpayment recovery.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII Social Security Act:

(a)	Section 1861(e)	-	Hospital
(b)	Section 1861(v)(1)(A)	-	Reasonable Cost
(c)	Section 1862(a)(14)	-	Exclusions from Coverage
(d)	Section 1866(a)(1)(H)	-	Agreements with Providers of Services
(e)	Section 1886	-	Payment to Hospitals for Inpatient Hospital Services

2. Regulations - 42 CFR 403, Subpart C:

Section 403.300ff	-	Recognition of State Reimbursement Control Systems

3. Regulations - 42 CFR 405, Subpart D:

(a)	Section 405.406 (Redesignated 413.20)	-	Financial Data and Reports
(b)	Section 405.452 (Redesignated 413.53)	-	Determination of Cost of Services to Beneficiaries
(c)	Section 405.453 (Redesignated 413.24)	-	Adequate Cost Data and Cost Finding

4. Regulations - 42 CFR 405, Subpart E:

(a)	Section 405.501	-	Determination of Reasonable Charges
(b)	Section 405.550(e)	-	Effect of Physician's Assumption of Operating Costs

5. Regulations - 42 CFR 489, Subpart B:

(a)	Section 489.23	-	Special Provisions for Waiver of Certain Inpatient Hospital Services Requirements

6. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1):

Section 2804	-	Special Procedures for Hospitals with Extensive Direct Billing of Non-Physician Services Under Part B

7. Other:

(a) Social Security Amendments of 1967 (Pub. L. 90-248), Section 402

(b) Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248), Section 108.

(c) Social Security Amendments of 1983 (Pub. L. 98-21), Section 602(k).

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post hearing briefs find and concludes that the Intermediary correctly determined the amount of the offset against the Provider's Part A payments as required by Section 602(k) of the Social Security Amendments of 1983. The Intermediary's adjustment is affirmed.

The Board finds that it was reasonable for the Medicare Carrier to use the percentages reported on Schedule II in order to determine the technical component portion of the total Part B charges billed by the ancillary physicians. The

record shows that the Provider elected to use the statewide averages reflected on Schedule II in order to assure its compliance with the 125 percent test required for approval of the Section 602(k) waiver. Having made this election and obtaining the HCFA-RO's approval of these percentages, there is no question that the Provider is locked-in to the statewide averages for purpose of the 125 percent test. The only other alternative available to the Provider at the time of the waiver approval process was the estimated percentages developed for each of the ancillary physicians as reported on Schedule I. Since the HCFA-RO questioned the use of Schedule I because of the lack of basic documentation requirements, it is doubtful that the percentages reflected on Schedule I could have been substantiated for the purpose of obtaining approval of the Section 602(k) waiver. Moreover, even the Provider's Chief Executive Officer referred to the data on Schedule I as the best estimates the doctors could come up with in short notice without the benefit of accurately accumulated costs. In many cases, he believed the doctors sort of made 'hallway' estimates of what they thought their percentages would be (TR I, 99). Accordingly, the Board finds that Schedule II was the only acceptable alternative available and that it was reasonable for the HCFA-RO to accept the statewide averages proposed by the Provider for meeting the Section 602(k) waiver criteria.

Since the Provider is locked-in to the statewide averages on Schedule II for compliance with the 125 percent test, it is the Board's conclusion that the Provider is obviously locked-in to the same percentages for the purpose of computing the required offset of Part B billings against the Part A payments. The Board finds that compliance with the specific provisions of Section 602(k) and the waiver procedures established under 42 CFR 489.23 can only be achieved by utilizing the actual Part B billings submitted by the ancillary physicians and the

actual Part B payments made by the Medicare Carrier. The Provider cannot later substitute the lower HSCRC rates to compute the offset based on rulings which were never implemented or events which never occurred. The Board notes that if the HSCRC rate had been used from the inception of the waiver process, it is extremely doubtful that the Provider would have met the 125 percent test based on the data presented in this case (total billings at HSCRC rates of $1,540,281 represent merely 49.4 percent of the Intermediary's offset determination of $3,119,928 using the Schedule II percentages). Accordingly, the Provider would not have qualified for the Section 602(k) wavier in the first place if the HSCRC rates were utilized.

The Provider has presented extensive arguments as to the HSCRC's authority to set the technical component rate which the ancillary physicians should have used in billing for their Part B services. Whether or not the HSCRC may have had such authority, the facts show that the HSCRC never enforced the use of these rates and the ancillary physicians never used the HSCRC's rate structure in billing the Part B carrier. The Provider cannot expect the Intermediary to apply an offset methodology based on a concept which never existed. It is the Board's conclusion that the methodology applied by the Intermediary is the only available alternative which conforms with congressional intent, the requirements of the law, regulations and program instructions and the facts presented in this case.

DECISION:

The Intermediary's method used to offset Part A payments under Section 602(k) of the Social Security Amendments of 1983, Pub. L. 98-21, was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick
Joseph F. Sloan

FOR THE BOARD:

NOV 5 1990

Arthur P. Owens
Acting Chairman

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
June 2, 1993

No. 92-2068
CA-90-3316-B

PGDH LIQUIDATING TRUST, as successor in interest to Prince George's Hospital, Incorporated, t/a Doctors' Hospital of Prince George County

Plaintiff - Appellant

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

Defendant - Appellee

On Petition for Rehearing with
Suggestion for Rehearing In Banc

The appellant's petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied,

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

For the Court,

/s/ Bert M. Montague

CLERK

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
July 14, 1993

No. 92-2068
CA-90-3316-B

PGDH LIQUIDATING TRUST, t/a Doctors' Hospital of Prince George County, as successor in interest to Prince George's Hospital, Incorporated

Plaintiff - Appellant

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

Defendants - Appellees

ORDER

The Court substitutes Donna Shalala for Louis Sullivan as a party respondent to this proceeding.

For the Court,

/s/ Bert M. Montague

CLERK

Section 602(k) of the Social Security Amendments of 1983, Pub. L. 98-21, § 602(k), 1983 U.S.C.C.A.N. (97 Stat.) 65, 165-66 (*reprinted in* notes following 42 U.S.C.A. § 1395y (West 1992)):

> (k) The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of sections 1862(a)(14) and 1866(a)(1)(H) of the Social Security Act in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under part B of title XVIII of such Act for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under part B of such title but that the payments to such hospital under part A of such title shall be reduced by the amount of the billings for such services under part B of such title. If such a waiver is granted, at the end of the waiver period the Secretary may provide for such methods of payments under part A as is appropriate, given the organizational structure of the institution.

Section 602(e)(3) of the Social Security Amendments of 1983, Pub. L. 98-21, § 602(e)(3), 1983 U.S.C.C.A.N. (97 Stat.) 65, 163, *codified as amended,* 42 U.S.C.A. § 1395y(a)(14) (West 1993 Cum Supp.):

§ 1395y. Exclusions from coverage and Medicare as secondary payer.

(a) Items or services specifically excluded:

Notwithstanding any other provision of this subchapter [Subchapter XVIII -- Health Insurance for Aged and Disabled], no payment may be made under part A or part B of this subchapter for any expenses for items or services --

* * *

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or rural primary care hospital by an entity other than the hospital or rural primary care hospital, unless the services

are furnished under arrangements (as defined in section 1395x(w)(1) of this title) [*see* App. 68] with the entity made by the hospital or rural primary care hospital;

* * *

42 U.S.C.A. § 1395x(w)(1) (West 1993 Cum. Supp):

§ 1395x. Definitions.

For purposes of this subchapter [Subchapter XVIII -- Health Insurance for Aged and Disabled]

* * *

(w) Arrangements for certain services; payments pursuant to arrangements for utilization review activities

(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, rural primary care hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this subchapter, discharges the liability of such individual or any other person to pay for the services.

* * *

42 C.F.R. § 489.23 (1985) (Final Rule published on Jan. 3, 1984, 49 Fed. Reg. 234):

§ 489.23 Special provisions for waiver of certain inpatient hospital services requirements.

(a) *General rule.* For any cost reporting period beginning before October 1, 1986, HCFA may waive the requirements of §§ 489.20(d) and 489.21(f), regarding items and services furnished to hospital inpatients, for a hospital that --

(1) Since before October 1, 1982, has extensively followed the practice of allowing suppliers of items and services furnished to the hospital's inpatients to bill directly under Medicare Part B for those items and services; and

(2) Could not comply with the requirements of §§ 489.20(d) and 489.21(f) by October 1, 1983 without threatening the stability of patient care furnished to its inpatients.

(b) *Procedure.*

(1) The hospital must submit a written request to its intermediary for a waiver under this section not later than September 10, 1983.

(2) The intermediary will forward the request and their opinion as to whether the hospital meets the criteria for a waiver to the appropriate HCFA Regional Office within 10 days of receipt of the request.

(3) The Regional Office will determine if the hospital's waiver request meets the criteria of paragraph (c) of this section.

(4) The Regional Office will notify the hospital whether its waiver request has been approved not later than October 1, 1983.

(5) The Regional Office's determination to approve or deny a waiver request is final.

(6) The hospital must request revocation of a waiver under this section in writing at least 60 days before the date on which the revocation is to take effect.

(7) Upon 60 days written notice, the Regional Office may revoke a waiver under this section if the outside supplier does not comply with the terms of the billing agreement under paragraph (c)(2) of this section.

(8) Unless a waiver is revoked, it will apply to all cost reporting periods beginning before October 1, 1986.

(c) *Waiver criteria.*

(1) The hospital must show that before October 1, 1982, a significant proportion of all ancillary services furnished to the hospital's inpatients have been furnished by outside suppliers and directly billed by those suppliers under Medicare Part B.

(2) The criteria in paragraph (c)(1) of this section are met if --

(i) The outside suppliers' reasonable charges for nonphysician services in the hospital's base period (as described in § 405.474(b)(1) of this chapter) were at least

125 percent of the reasonable cost of the nonphysician ancillary services furnished to Medicare inpatients by the hospital exclusive of the costs of operating room, recovery room, labor and delivery room, pharmacy, and medical supplies; and

(ii) The hospital's inpatients received at least three distinct types of ancillary services (such as pathology, radiology, and physical therapy services) primarily from outside suppliers.

(3) The hospital must show that outside suppliers furnishing items and services to its Medicare inpatients under the waiver have agreed that --

(i) The supplier will bill only for services for which payment may be made under Part B (or would be made if the beneficiary were entitled to Part B benefits);

(ii) The supplier will bill the program directly for services furnished to an inpatient of the hospital (even if - assignment is not accepted) within 30 days of his or her discharge from the hospital; and

(iii) The supplier's billing will specify that the services were furnished to an inpatient of a particular hospital, identify the nonphysician services that were furnished, and identify the charge for each service.